Nord. Psykiatr. Tidsskr. 1981, 283—298

Psychiatric hospital treatment in the United States*

Otto F. Kernberg

Medical Director, The New York Hospital-Cornell Medical Center, Westchester Division
Professor of Psychiatry, Cornell University Medical College
Supervising Analyst, Columbia University Center for Psychoanalytic Training and Research

1. Historical background

In the first half of the 18th century, against the background of a generally fearful, suspicious, and punitive attitude toward the mentally ill, psychiatric patients were confined to poorhouses, prisons and orphanages. It was in the second half of the 18th century that, under the influence of the enlightenment, a more concerned and optimistic attitude toward the mentally ill developed in the United States, heralded by the opening, in 1752, in the cellar of the Pennsylvania Hospital in Philadelphia, of the first separate unit for psychiatric patients.

Thirty-one years later, Benjamin Rush, appropriately called the "father of American psychiatry", became a member of the staff of the Pennsylvania Hospital, and for many years took the responsibility for those mental patients. His own observations and the influence of Phillipe Pinel led him to propose a dual approach to treating the mentally ill: direct treatment of the body, and indirect treatment of the body through the medium of the mind. While the physical aspects of the treatment of that time seem somewhat barbaric, the psychological attitude Rush advocated had a humanistic orientation. He recommended, for example, that the physician listen sympathetically to his patients, provide them with opportunities to relieve their minds, and treat them with respect and consideration.

Under the influence of Phillipe Pinel and the description of the York Retreat by Samuel Tuke, optimistic and humanitarian trends regarding the treatment of the mentally ill began to influence the medical and public thinking in the United States in the early 19th century, and led to the opening of various asylums and state hospitals which attempted to carry out therapies inspired by what was called "moral treatment". Moral treatment, in essence, attempted to re-educate the mental patient by providing him with a therapeutic milieu — the opportunity for an organized daily schedule, including activities and entertainment; the possibility of prolonged social retreat by locating the psychiatric institution in a rural area; and ongoing personal contact with a physician who would carry out a fatherly function of encouragement and limit-setting. Many contemporary principles of hospital milieu treatment stem from the organization of the therapeutic milieu developed under the influence of the philosophy of moral treatment.

Strong countercurrents characterized the development of psychiatric hospitals in the United States during the second part of the 19th century. The philosophy of moral treatment continued to inspire the hospitalization of mental patients in small private psychiatric hospitals and in a few large state hospitals. The hope that such an enlightened treatment might eventually permit the social reintegration of mentally ill patients fostered a trend toward establishing a widespread system of public psychiatric hospitals. Dorothea Lynde Dix, a lay crusader for mental health, personified this hope and the

* Presented at the 125th Anniversary Celebration of the Gaustad Hospital, Oslo, Norway, November 17, 1980

humanitarian trend of the moral treatment philosophy.

The early hopes for effective treatment and cure of mental illness by moral treatment soon proved illusory, however, and the sheer numbers of mentally ill people requiring hospitalization created significant financial constraints for the development of well-staffed and well-run hospitals. Financial reasons motivated the states to build larger and larger psychiatric hospitals, the majority of which reverted to the traditionally custodial, indifferent, and overcrowded conditions under which the mentally ill had been housed and isolated from the community in almshouses and prisons.

Nevertheless, psychiatric hospitals had now become part of the realm of the medical profession, and the scientific developments of the second part of the 19th century both in Europe and the United States led to an increasing interest in the physical aspects of mental disorders and brain pathology, and the search for organic treatment of mental illness. In practice, while efforts to protect the well-being of mental patients in large state institutions were promoted by state and federal legislatures, the actual conditions of life in most of these institutions were strikingly different from the ideals of moral treatment that continued to inspire the treatment in the relatively small number of private psychiatric hospitals. This double nature of care for the mentally ill — custodial treatment in large, overcrowded public institutions for the poor, and highly individualized, intensive treatment in small private institutions for the wealthy — continued to haunt American psychiatry in the first half of the present century.

These same years saw the discovery of the etiology of syphilis and malaria therapy for this illness, the classification of major psychotic syndromes by Kraepelin, the insulin treatment for schizophrenia, the effectiveness of electroconvulsive treatment for manic-depressive illness, and the development of brain surgery, all of which dramatically increased the armamentarium of organic therapies for mental illness and neutralized the traditional skepticism regarding recovery from it that had previously prevailed. Earlier in this century, the mental hygiene movement launched by Clifford W. Beers maintained the momentum of the moral treatment of the 19th century. Thus, both the organic approach mostly centered in the large state institutions, and the psychological tradition of moral treatment centered largely in a few small private psychiatric hospitals continued the dialectic interplay between organic and psychological treatment philosophies that would be re-enacted, in the second half of the 20th century, by the dialectic between the influence on hospital treatment of psychoanalytic principles and the therapeutic community, on the one hand, and of psychopharmacology, on the other.

2. Psychoanalytic contributions to hospital treatment

During the first half of this century, the large state hospitals, housing from hundreds to thousands of patients, had as their essential tasks to protect the community from mental patients and to provide for these patients over a long period of time a supportive environment within which medical treatment could be carried out. It was in the small private psychiatric hospitals housing from between fifty or less to two or three hundred patients that the higher staff/patient ratio allowed for the development of a new philosophy of hospital treatment based upon psychoanalytic principles.

This new current was expressed through three parallel approaches: (a) the interpersonal, culturalist one of Harry Stack Sullivan (and the related "psychobiological" one of Adolf Meyer), (b) the ego psychology approach applied by William Menninger, Robert Knight, and Paul Federn, and (c) the British object relations approach first applied by Thomas Main to "special cases" in the

hospital, and gradually integrated with the sociological approach of Stanton and Schwartz (Kernberg 1976, 1980).

a) The Sullivanian approach

Harry Stack Sullivan's early work at Sheppard and Enoch Pratt Hospital, in Towson, Maryland, from 1923—1930, and then at the Chestnut Lodge Sanitarium in Rockville, Maryland is summarized in several theoretical and clinical writings and by his leading disciples, particularly Frieda Fromm-Reichmann, Harold Searles and Otto Will. These views were reinforced by the independently arrived-at formulations on hospital treatment of Adolf Meyer at Johns Hopkins Hospital, and Lewis Hill at Sheppard Pratt.

Sullivan stressed that only interpersonal situations are open to psychological investigation, interpersonal situations that may be both real and fantasied intrapsychic experiences. He stressed that, normally, instinctual bodily needs are condensed with the need for other human beings, and he proposed that the dissociation between the strivings for basic bodily needs and the strivings for feelings of security that derive from the appreciation by others and determines self-esteem is a basic cause of psychopathology. At a certain level of severity of dissociation of need satisfaction from security satisfaction, severe anxiety develops, a dissociation of a good self from a bad self within the patient's self system, and a related, malevolent transformation of the normal capacity for tenderness into paranoid suspicion and self-hatred.

The essential task of hospital treatment, within this concept, is to overcome the patient's dissociation by means of intense psychotherapeutic interpersonal interactions with the therapist which bring the dissociated needs into focus and permit the resolution of the transferential ("parataxic") distortions, in the course of which the patient re-experiences his past intrapsychic relations with others in the interactions with the therapist. The resolution of severe anxiety linked to such dissociative conflicts fosters growth in the interpersonal relation the patient establishes with the therapist.

The social structure of the hospital should facilitiate the gathering of information about all the patient's interactions around the clock, and tolerate that the patient express his pathological, regressive needs without being rejected or abandoned. All hospital staff should interact with the patient in terms of their availability as persons rather than as a function of specific skills. All the information gathered from the patient's interactions within the hospital setting should be channeled to the therapist, so that the therapist can integrate it and use it in his own psychotherapeutic work.

The psychotherapist, with his interpretive interventions, is the principal therapeutic instrument. The patient's negative transference is interpreted in the light of the understanding of the meaning of the parataxic distortions that are enacted, while the positive transference is mostly utilized for facilitating the patient's growth through the resumption of the normal development of interpersonal gratifications in the therapeutic situation, and secondarily, by growth-promoting relations with other staff as well. According to Harold Searles, establishing a "symbiotic" relationship in the therapy of schizophrenic patients, and gradually sorting out the patient's ego boundaries and the reality of the situation permits the patient's self to separate from the therapist and to consolidate his ego boundaries in the process.

In short, the Sullivanian orientation focuses on the dynamics of the current interaction in the hospital, on the alert participation of all personnel in gathering information, and in the interpretation of all interactions by the psychotherapist. The hospital milieu program should facilitate the psychotherapy, but is not as essential as the interactions with the therapist and the facilitation of individual models for identification that the patient may choose within the hospital.

b) The ego psychological approach

From 1927 to 1931, Ernst Simmel (1929) in the Tegel Sanitarium near Berlin attempted to develop new methods of hospital treatment based upon psychoanalytic principles. After the Nazis closed the sanitarium Simmel's ideas inspired William Menninger (1936) and, later, Robert Knight (1953a, b).

The ego psychology orientation of these authors, gradually enriched by the theories of Paul Federn, Heinz Hartmann and David Rapaport, focused on the hospital treatment, not of schizophrenic patients (Sullivan's major interest), but of patients with severe neuroses and character pathology requiring hospital treatment. It was in studying this group of patients that Knight developed his pioneering understanding regarding borderline conditions, first at the C. F. Menninger Memorial Hospital in Topeka, Kansas, (between 1937 and 1951) and after that at Austin Riggs Sanitarium in Stockbridge, Massachusetts.

Within this ego psychology concept the hospital constitutes a protective environment which permits the diagnosis of patients' transferences while protecting them against the consequences of destructive or self-destructive acting out. The patient's transference may be to other staff members and to the entire institution as well as to the therapist, so that the patient's total behavior needs to be explored. Hospital treatment should include psychoanalytic psychotherapy or psychoanalysis, as well as selective restriction of inappropriate behaviors, the analysis of these behaviors, and the reasons for the needs for this restriction.

At the same time, the hospital should provide socially acceptable outlets for instinctual needs. The therapeutic activities program should foster sublimated expression of aggressive needs. The experience of work, recreation, study, and artistic expression (the four principal areas of therapeutic activities in the hospital) provide opportunities for adaptive combination of impulse-defense compromises and therefore have direct ego-strengthening functions. The availability of an optimal hospital structure (in practice, a daily life in the hospital neither too rigidly nor too loosely organized) also has ego-building functions by providing experiences of growth and learning, by directly raising the patient's self-esteem as a consequence of his/her more effective functioning in the hospital, by decreasing the patient's fears of unconscious impulses because it provides external controls, and by offering new models for identification.

This concept of hospital milieu treatment encourages the patient's active involvement in therapeutic activities throughout the hospital stay, an individually tailored prescription of activities for patients as well as of specific attitudes and control provided by the staff for each patient. This approach was in line with the supportive psychotherapy that Knight (1953b) systematized for borderline patients, a treatment strategy that stressed the search for a more adaptive combination of impulse and defense expression by means of selective interpretation of some areas in the psychotherapy while leaving others untouched, and direct strengthening of adaptive and sublimatory ego functions in the therapy hours as well.

Paul Federn's work with psychotic patients focused on the loss of ego boundaries experienced by these patients, a loss determined, in his view, by a withdrawal of libidinal cathexes from ego boundaries, which Federn conceived of as a sense organ which helps the ego to distinguish reality from fantasy. In the psychotherapeutic treatment of schizophrenic patients, Federn suggested, it was important to foster the recathexis of ego boundaries by stressing the delimitation between the patient's self and others, by focusing the patient's interest and libidinal investment in a positive transference relation with the therapist and avoiding negative transference developments, and by providing a clear structure around him that would facilitate his redifferentiating from his environment. This psychotherapeutic approach fits natu-

rally with the use of the hospital structure as an instrument to reconstitute the ego. The hospital clearly delimits space, time, roles, and activities, thereby facilitating the reconsolidation of ego boundaries through all the patient's daily activities and interactions.

Heinz Hartmann's concept of the "conflict-free sphere" of the ego also influenced the ego psychology approach to hospital treatment in the sense of tapping the patient's ego resources by means of hospital milieu therapy, by building on whatever residual strength the patient had, and by avoiding regressive experiences that would foster the primitive, un-neutralized expression of aggression and promote further loss of ego boundaries by flooding it with this aggression. The ego psychology approach, in short, stressed the importance of a structured, environment focused on the confluence between ego-strengthening features in the environment and in the patient's psychotherapy, and de-emphasized the exploration of the negative transference in patients with ego weakness, particularly in psychotic patients (where most of the burden of the treatment was placed on the hospital milieu program).

c) Application of object relations approaches

Under this heading fall my own ideas on hospital treatment. The object relations approach derives from a variety of sources, some of them British, some American.

Thomas Main, in his paper "The Ailment" (1957), analyzed the group reactions of nurses who were treating borderline (and some psychotic) patients who had become "special cases" in the hospital. Main found that these patients activated group phenomena in the nursing staff similar to the basic assumptions groups described by Wilfred Bion in 1952. Bion later (1961) elaborated on his theory of the regressive phenomena that occur in small groups when their task structure (work group) fails. He described the development of certain basic emotional reactions within the group ("basic assumptions group"), reactions which exist potentially at all times but are activated particularly at times of breakdown of the task group. His descriptions of the "fight-flight" assumption, the "dependent" assumption, and the "pairing" assumption are sufficiently well known not to require further elaboration here. What is relevant here, is that Main concluded that regressed (particularly borderline) patients may, under certain conditions, activate their intrapsychic object relations in the interpersonal relations among the hospital staff: the patient elicits in his social field a re-enactment of the conflicts within his intrapsychic world. The activation of massive projection, the need for omnipotent control, denial, primitive idealization, and above all, splitting in the nursing staff reflects both the patient's intrapsychic mechanisms involved and the behavioral means by which staff relationships are distorted by the patient's intrapsychic world.

In 1954, Alfred Stanton and Morris Schwartz in a classical study based on their research at the Chestnut Lodge Sanitarium in Rockville, Maryland, proposed that the social and administrative structure of the psychiatric hospital has a significant impact on the individual patient's functioning, and that social pathology reinforces individual psychopathology. Stanton and Schwartz studied the effects of breakdown in staff morale and of covert disagreement among staff on patients' pathological excitement, particularly the activation of the "special case" syndrome. They illustrated how "splits" and covert conflict in the interpersonal and social fields of the hospital may intensify intrapsychic conflicts and disorganization in the "special" (borderline and in some cases psychotic) patients.

Thus, Stanton and Schwartz and Main provided a complementary set of formulations that illuminated the relation between social conflict in the hospital, on the one hand, and intrapsychic conflicts in patients with severe regression, on the other. The finding that the patient's intrapsychic conflicts and the potential cleavages and stresses

within the hospital's social system reinforce each other, constitutes a most important bridge between the understanding of the hospital as a social system and the understanding of the activation of pathology of internalized object relations of patients in that social system.

These findings and theoretical considerations led me to investigate the general theoretical formulations of the British object relations school, particularly the description by Fairbairn and Melanie Klein of primitive defensive operations, primitive object relations, primitive aggression, and primitive transferences reflecting all of these.

The ideas from Main's pioneering paper of 1957, from Bion (1961), and from Stanton and Schwartz (1954) were first integrated into a philosophy of hospital treatment and applied at the C. F. Menninger Memorial Hospital in the early 1970s (Kernberg, 1976). These concepts also influenced the American counterpart to the Tavistock Institute for Human Relations, namely, the A. K. Rice Institute of the Washington School of Psychiatry, which applied Kenneth Rice's contributions to group psychology (1965) in conferences for mental health professionals throughout the United States from the late 1960s on. The diagnosis of primitive defensive operations, particularly splitting mechanisms within the patient and within the immediate social group under the effects of the patients' pathological interactions in the hospital, resulted in a related emphasis on the interpretation of such primitive transferences in the psychotherapy of hospitalized borderline and psychotic patients, and a stress on primitive aggression as a fundamental source of intrapsychic conflicts.

This interpretive work with the transference differed from both the ego psychology approach of Federn (who had recommended building on the positive transference and avoiding the negative transference) and from the Sullivanian school (which focused on the growth potential of current developments, in contrast to the analysis of genetic issues in the transference). At the same time, the theoretical link between Stanton and Schwartz's ideas about the hospital milieu and Main's findings regarding the patient's intrapsychic functions suggested that the hospital milieu had a therapeutic use in addition to serving as an ego-strengthening device; it could serve as a setting within which the patient's intrapsychic conflict could be played out in the context of group processes, diagnosed in the social field by hospital staff, and brought back into the individual psychotherapeutic work with the patient.

Thus, the effects of the object relations approach included a renewed focus on psychoanalytic psychotherapy — particularly with patients presenting severe character pathology and borderline personality organization — a psychoanalytic exploration of group processes, and a reorganization of hospital treatment to permit a combination of these individual and group methods. In contrast to the supportive psychotherapy with borderline conditions and the corresponding supportive functions of the hospital milieu developed by Knight, this newer approach fostered an interpretive approach both to the patient's transference in individual psychotherapy and to the regressive group processes in the hospital.

3. Sociological approaches and the therapeutic community

Stanton and Schwartz (1954) finding that covert disagreement of staff could cause regressive behavior in individual patients pointed to potentially antitherapeutic effects of hospital treatment. William Caudill (1958), at the Yale Psychiatric Institute — another psychoanalytically oriented small psychiatric hospital — studied the effects of the relations between staff group and patient group on the vicissitudes of the development of individual patients in the hospital setting. He found that the isolation of patients from staff, encouraged by a hierarchical hospital structure,

negatively affected the treatment of individual patients as well as the functioning of the patients as a group. Caudill described how imposing a "patient role" on the patient, the peer pressures for socialization and for accepting the doctors' value system — together with the patients' opposition to authority (particularly to nursing staff) — foster mutual ignorance of patients and staff, stereotyping, and alternations between permissiveness and restriction in the form of cultural "ground swells", which strongly influence all treatment carried out in the hospital.

Ivan Belknap (1956) and Erving Goffman (1961) studied the effects of the social structure of the hospital on the treatment of psychiatric patients in large public institutions. Their conclusions stressed even more sharply than the investigators previously mentioned the regressive and degrading effects of the traditional hierarchical system in large hospitals, where the deterioration of patient's self-respect and the general prison atmosphere complemented the arbitrary and authoritarian control exerted by the lowest echelons of the hierarchically organized staff. Goffman linked life in the large psychiatric hospital to his studies of other "total institutions", such as armies, prisons, labor camps, ships at sea, and monasteries, and pointed to the dramatic discrepancies between the ideal aims of institutions and their actual functioning as determined by expediency and tradition. He described the "dehumanizing" of the patient so that he could be more easily dealt with as just another unit in a "batch", the regulating of all activities by the "privilege system", which consists essentially of measuring a patient's health in terms of his obedience, and the process by which the patient accommodates himself to the actual conditions of institutional life.

As a result of these developments in the 1950s, a strong consensus developed in the 1960s within the profession of psychiatry in the United States that the traditional large public psychiatric hospital included important anti-therapeutic features, and that long-term hospitalization could, by itself, adversely affect the optimal treatment of many patients. This conviction gradually merged with the political ideologies of the 1960s increasingly questioned traditional authority in general and reflected, together with the community mental health movement, the struggles against the war in Viet Nam, and the aspirations of the counter culture, the influence within the United States of the anti-psychiatry movement that was then evolving in Europe. The pendulum thus swung to one extreme, leading to a questioning of hospital treatment in general, and an urgent search for alternatives to long-term hospitalization (and, in some extreme views, for alternatives to all hospital treatment for psychiatric patients).

Paradoxically, however, while these sociological studies and conclusions ended up questioning psychiatric hospital treatment in general, a contrary trend evolved out of the study of authoritarian features in small psychiatric hospitals. This contrary trend was the effort to transform the traditional psychiatric hospital into a nonauthoritarian, democratically inspired social system within which patients would be able to find new sources of emotional growth and self-esteem by effective participation in determining the nature and activities of their daily life in a protected environment. Here the sociological studies of Stanton and Schwartz and of Caudill, and the various psychoanalytic approaches converge to transform the psychiatric hospital, particularly the small psychiatric hospital setting.

The concept of therapeutic community treatment emerged as a direct challenge to the regressive and antitherapeutic effects of the traditional psychiatric hospital functioning along a hierarchical medical model. Thomas Main and Maxwell Jones originally developed the concept of the therapeutic community as a treatment modality and as a democratization of the treatment process. The therapeutic community modality of treat-

ment is an expansion of the concept of the "team approach" to diagnosis and treatment that gradually emerged in contemporary psychiatry. In contrast to more traditional types of distribution of the decision-making authority among various disciplines according to the tasks involved within a team approach, in a therapeutic community the opposition to a hierarchical distribution of authority goes beyond a functionally required delegation of authority for any concrete tasks. In the typical therapeutic community, the aim is to minimize hierarchical levels stemming from professional expertise, degrees, and titles and to maximize a democratic decision-making process.

In addition, Jones and Main emphasized the following features: (1) Community treatment: Staff and patients function jointly as an organized community to carry out the treatment of the patient population; patients actively participate in and are co-responsible for their own treatment, not passive recipients. (2) Therapeutic culture: All activities and interactions should relate to the goal of re-educating and socially rehabilitating patients. The optimal functioning in the therapeutic community would be the first phase in promoting the patient's optimal functioning in the external community. (3) Living-learning-confrontation: An open flow of communication between patients and staff provides immediate feedback regarding observed behaviors and reactions to them. An exploration of the functions of these behaviors in the "here and now", and of alternative, new, experimental behaviors would help the patients to cope in the therapeutic community and in the external community.

The therapeutic community approach fosters the use of small group, large group, and task group meetings to facilitate open communication, to generate pressures in the direction of socialization and rehabilitation, and to foster a democratic — in contrast to an authoritarian — process of decision making. Within these various group meetings, the following stand out: (1) The community meeting, which includes all staff and focuses on the examination of the total social environment in which staff and patients participate. (2) Patient government: An organization of the patient's group for the purpose of having the patients participate in the social and decision-making processes. (3) Staff meetings: These complement patient government, express the concept of democratic decision-making among staff, and allow for optimal interactions and democratic distribution of authority in all areas involving staff and staff/patient interactions.

Therapeutic community models were developed in various hospitals in the United States in the 1960s; leading experiments in this direction took place at Fort Logan in Colorado, at the Austin Riggs Center in Massachusetts, and at Yale Psychiatric Institute. These early experiments were followed by various applications at the C. F. Menninger Memorial Hospital in Kansas, at the New York State Psychiatric Institute in New York, and at the Westchester Division of The New York Hospital on which I have reported elsewhere (Kernberg, 1981 a, b).

Thus, while the anti-authoritarian and prodemocratic "ground swell" of the 1960s fostered criticism of psychiatric hospitals, it simultaneously resulted in the development of new experimental models of hospital administration which linked the administrative structure with the use of group processes, and it facilitated the examination of the total social system in which the patient developed his life in the hospital. Therapeutic community approaches strengthened the new psychoanalytically derived concepts of hospital treatment and dramatically enriched the armamentarium of treatment modalities and techniques within the psychiatric hospital. These two contradictory trends of the 1960s, one toward the elimination of psychiatric hospitals — particularly of long-term hospital treatment — and the other, the enrichment of psychiatric hospital treatment with new therapeutic modalities, reflected, from a historical perspective, a new phase in the

dialectic between the large public institutions and the small psychiatric hospitals characteristic of psychiatric hospital treatment in the United States.

In the short run, in the early 1970s, the first trend — toward significant restriction and elimination of hospital treatment — prevailed. But in the second half of the 1970s, the results of emptying out the large state hospitals generated a sobering awareness of the differences between ideologically determined concepts of eliminating institutional treatment, on the one hand, and the reality of how patients fared in outpatient alternatives to hospital treatment, on the other. What follows is a summary of the developments, findings, and trends of the past twenty years in the United States.

4. Community psychiatry, deinstitutionalization and transinstitutionalization

The introduction of the neuroleptics in the 1950s, gradually expanding into a broad armamentarium of psycho-pharmacological treatment in the 1960s, had contributed to a dramatic decrease in the resident patient population of the large state and county mental hospitals. From a high of 559,000 patients in 1955, resident patients in state mental hospitals decreased to 200,000 in 1970 and 193,000 in 1976. This trend was reinforced by the rise of Community Mental Health Centers throughout the country in the late 1960s and early 1970s.

In 1961, the Joint Commission on Mental Illness issued its report, "Action for Mental Health". It recommended placing strong emphasis on community-based services, called for a reduction in size, conversion to long-term medical facilities, and, where possible and appropriate, the closing of large state hospitals and for creating replacement services in the community. President Kennedy included many of these ideas in his recommendations to Congress, which culminated in the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963. In 1965, Congress enacted a law providing federal funds for staffing of Community Mental Health Centers. These Centers were to provide five basic services: inpatient treatment, emergency services, partial hospitalization, outpatient services, and community consultation and education. Each Center was assigned to serving a "catchment area," a geographic region with a population of 75,000 to 200,000 people. In 1975, further legislation added services for children, for the aged, follow-up services for patients formerly in institutions, screening services before admission to state hospitals, services for alcoholism and drug abuse, and transitional housing services. In 1975 the law also required that the governing board of Community Mental Health Centers be a community organization. The development of psychiatric units representing the inpatient component of Community Mental Health Centers in or close to general hospitals channeled psychiatric hospitalization and total psychiatric treatment from isolated state hospitals to the local communities where patients resided. It also fostered, in combination with the effects of psychopharmacological treatment, a reduction in the length of stay for inpatients and the development of alternatives to full hospitalization. At the same time, however, total admission to inpatient services increased from 178,000 in 1955 to 390,000 in 1972, indicating the tendencies toward shorter length of stay and a higher rate of readmission (Feigelson, 1980; Langsley, 1980).

Strong ideological currents incorporating the social criticism of the negative effects of institutionalization, the "antipsychiatry" philosphy (which considered all treatment based upon traditional hierarchical medical models suspect and wanted to promote the autonomy, self-respect, and self-determination of psychiatric patients), the democratic aspirations of the therapeutic community, the

optimism generated by the effects of psychopharmacological treatment and the community mental health movement — all these combined in promoting de-institutionalization of the mental patient as a primary aspiration of the psychiatric profession. Several research findings, highly publicized because they fit into this social atmosphere, indicated the effectiveness of alternatives to hospitalization.

Pasamanick et al. (1967) compared a population of hospitalized patients with an experimental population of patients receiving specially designed home care. Significantly fewer of the hospitalized patients were able to remain in the community, after completion of their treatment, than patients from the home-care population. A five-year follow-up report, however, presented a more pessimistic outlook, indicating that there was little difference between those patients who were placed in home care and those who were hospitalized; the follow-up showed that the results were uniformly poor. Herz et al. (1971, 1975), comparing day hospital treatment with inpatient treatment of a population selected because both treatment modalities were deemed appropriate to all of them, concluded that the inpatients had a higher readmission rate than the day hospital patients, and that, after four weeks, a small but statistically significant improvement of day hospital over inpatient had occurred. Herz (1980), in a critical review of recent research and literature on the advantages and disadvantages of hospitalization, concludes that the day hospital is not only a feasible alternative to inpatient care, but may be generally preferable except for severely disturbed, acutely psychotic patients and seriously impaired acute and chronic patients who do not have adequate social support systems in the community.

In looking back over the research efforts that supported the assumption that alternatives to hospitalization may be preferable in the treatment of many psychiatric patients, one cannot help but notice the difference between the quality of the alternative care provided in experimental studies and the actual reality of the alternatives to hospital care for the large majority of psychiatric patients in state and county hospitals in the United States. The "anti-hospitalization" ideology inhibited a full evaluation of the social and financial costs of alternative treatment arrangements in comparison to the cost of hospital treatment for mental patients.

In many cases, state legislatures and commissioners of mental health enthusiastically adopted the philosophy of de-hospitalization because it meant a significant decrease in their system's inpatient population and, therefore, in the financial burden for state governments. The result was a strange alliance between economy-minded legislatures and psychiatric administrators, on the one hand, and idealistic community mental health psychiatrists, on the other. And when tens of thousands of patients were literally dumped from large institutions into the local communities without adequate support systems, the communities protested. From 1975 to 1980, a number of inquiries and reports pointed to the dismal living conditions of the de-institutionalized former mental patients, and it became evident that one effect of the de-institutionalization movement had been a "trans-institutionalization", (Michels, 1980) that is, the chronically ill had simply been moved from the frying pan to the fire. They were now living in poorly designed, inadequately supervised, substandard nursing homes and other places.

Another negative consequence of allowing ideological considerations to take precedence over patients' needs was evident in the functioning of many community health centers. In order to democratize the treatment, efforts were made to involve the local community in leadership functions of these centers. Community "participation" — interpreted as community control by many — guaranteed by mandated advisory groups which would represent consumers' and citizens' interests fostered, in practice, a political organization

of certain community groups that utilized participation in community mental health centers for purposes only indirectly related to the treatment of the mentally ill. In some instances, mental health professionals, in an effort to involve the local community in the treatment of mental patients, trained nonprofessionals to take over professional functions, relinquished quality control, and permitted a deterioration of the quality of services to occur that led, in some circumstances to severe political conflicts between community groups and mental health officials.

A typical case was that of the Lincoln Hospital in the South Bronx in New York City. The director and the staff of the community mental health program developed training programs for poor people as mental health workers and invited community residents and local agencies to participate in the planning of mental health programs. Eventually, the program dissolved in chaos as a result of political fights between professionals and paraprofessionals, minority groups, and the medical school that sponsored the program. Similar failures occurred in Philadelphia, Boston and other metropolitan areas (Langsley, 1980).

Perhaps the most serious problem that significantly discouraged the community mental health movement and led to widespread disappointment in the second half of the 1970s was the discrepancy between the many functions they were expected to perform and the inadequacy of their staffing. Again, the clash between ideology and good intentions, on one side, and fiscal realities and technical requirements, on the other, was dramatic. In an effort to control the cost of operating community mental health centers, consistent efforts were made to replace the most expensive professionals (psychiatrists) by less expensive and less well-trained professionals, leading to a significant decrease in the level of professional functioning, disappointments on the part of the most highly trained and — by the same token — overworked professional staff, dissatisfaction with the quality of medical care provided, "burn out" symptoms, and finally, the psychiatrists' abandonment of the community mental health system.

Within the small psychiatric hospitals, too, the ideological currents of the therapeutic community movement produced corresponding disappointments. Having examined the problems and shortcomings of therapeutic community models elsewhere (Kernberg, 1981b), I shall only mention the most salient of these problems here. First, the "democratization" of ward management often neglected the relation between any particular service and the hospital itself or (in cases where an entire small psychiatric hospital was transformed into a therapeutic community) the administrative relations with the medical director or the governing board of the hospital. Endless political struggles and confusion reflected the neglect of theory of administration on the part of some proponents of therapeutic community models.

Another important problem was the proliferation of group processes which, in immobilizing large numbers of staff in frequent meetings, reduced effective staff time for dealing with the individual patient's problems, obscured the nature of medical responsibility and accountability for treatment, and permitted patients with good surface functioning but subtle manipulative and antisocial features to become experts in controlling the system. In addition, regressive group processes often counteract the positive effects of group meetings, permit the acting out — in the form of chronic passivity or random aggressiveness — of pathological needs of all involved, and interfere with the patient's need for and right of privacy.

Most important, therapeutic community models tend to foster the illusion in the hospital of an ideal society that eliminates the contradictions of ordinary social life; these models create an ecstatic, messianic atmosphere which militates against rehabilitating

the patients to functioning outside the hospital. Finally, these therapeutic community models tend to increase both the satisfactions of human needs among staff and the expectations for such satisfactions — expectations that are usually not realized — which contribute to overwork, exhaustion, and, eventually "burn out" symptoms.

Therapeutic community models, however, also have provided new insights into the group processes that affect patients' development and treatment; they have increased the sophisticated use of hospital milieu treatment, the use of the total social environment of the hospital for therapeutic purposes. These positive effects have contributed to the contemporary developments in theory of hospital treatment and of techniques for optimal utilization of hospitalization that lead us to the paradox of a renewed interest in hospital treatment in very recent times in contrast to the trend away from hospitalization in the 1960s and early 1970s.

To summarize the developments in psychiatric hospital treatment in the United States in the last two decades, the most dramatic developments have been the possibility of more intense treatment and shorter length of stay derived from the psychopharmacological treatment of schizophrenia and manic-depressive illness, and the increasing utilization of individual psychotherapy, group processes, hospital milieu and activities programs, and therapeutic community models for diagnosis and treatment of severe character pathology and the borderline conditions. An in part ideologically determined tendency to discharge patients prematurely from the hospital without adequate community support has led to the "revolving door" phenomenon of multiple hospitalization and to the dumping in the community and social neglect of the chronically ill psychotic and organic patients. Appropriately intermittent hospitalization differs from "revolving door" phenomena. The overextension of the psychiatric and mental health professions with social and political affairs of local communities, particularly in underprivileged areas, under the influence of an ideology of social action, has contributed to the weakening and deterioration of some features of community psychiatry and brought about a disappointment with this modality of treatment (an integrated network of inpatient, part-hospitalization, outpatient, and outreach programs), which, appropriately staffed and professionally managed, may significantly increase the provision of mental health services to the community. In retrospect, the polarization between hospital treatment and community treatment seems ideologically motivated and technically absurd. On the basis of contemporary knowledge, of clinical and research evidence, a broad spectrum of psychiatric modalities of treatment that include the availability of short-term and long-term hospital treatment in conjunction with partial hospitalization and all other outpatient modalities would seem to be an optimal model of care.

5. Current trends

Perhaps the most important trend to emerge in recent years in the United States is the recognition of the need to develop particular services for particular patient populations. In contrast to the traditional tendency to treat "mental patient" as a homogeneous group as far as hospital treatment and community facilities were concerned, there is an emerging, recognized need both from a clinical and a research aspect to devise treatment programs and facilities appropriate to specific patient categories.

Within the psychiatric hospital itself, specific services are needed to serve different populations. A large psychiatric state hospital, for example, should, ideally, be subdivided so as to provide both acute and long-term treatment services, and, within the long-term service, some should be geared to intensive, treatment of character pathology, others to the treatment of the severely deteriorated chronic psychotic patient or the custodial support of severely ill organic patients, all of

them with different staffing and programs. Small psychiatric hospitals would necessarily have to specialize in only some of the following areas, except where staff/patient ratio is very high; the variety of treatments offered can then be augmented, but the treatment costs will be very high as well.

The hospital services for acute, short-term treatment would expect the average length of stay to fluctuate from 30 to 90 days. Such hospital services would be ideal to treat acute psychotic illness and to provide a full range of medical and psychiatric diagnoses and treatment, as well as a sophisticated use of the armamentarium of psychopharmacology, psychosocial rehabilitation and initiation of aftercare. Such acute services may specialize further in the acute hospital treatment of alcoholism and drug addiction, for affective illness, schizophrenia, and transitory reactive psychosis reflecting the acute organic brain syndrome or temporary regression of borderline conditions. Specialized child and adolescent inpatient services represent one more highly differentiated modality of hospital treatment. Some crisis intervention may be carried out concomitantly with brief hospitalization, although most crisis intervention would be carried out in a day hospital setting or an outpatient setting.

Long-term hospitalization is indicated for patients with chronic regression who have not responded to treatment and are unable to function in anything but the well-structured hospital, and for patients with frequent and prolonged psychotic episodes where psychotherapeutic modalitites of treatment in addition to psychopharmacological ones seem indicated. Long-term hospitalization is particularly indicated for patients with severe character pathology and borderline conditions who are extremely self-destructive or present such disorganized functioning that they need the protection of the hospital in order to participate in a therapeutic program.

Patients with borderline personality organization and low impulse control, severe acting out, negative therapeutic reaction, low motivation for treatment, and antisocial features are prevalent in this group. Their program, however, may be different from that required for a subgroup of schizophrenic patients who do not respond to psychopharmacological treatment and look as if they would respond to intensive psychotherapy: this subgroup also requires long-term hospitalization but with a different structure of hospital treatment. Therapeutic community models are particularly indicated in the long-term treatment of character pathology and borderline conditions, while modified versions of the therapeutic community may have some value in the long-term hospitalization treatment of schizophrenic patients as well.

Long-term hospitalization geared largely to custodial functions is indicated for patients whose active treatment has convincingly proven to be ineffective, and who are unable to live in an environment less structured than a psychiatric hospital. In other words, an awareness seems to be growing that a relatively small but significant patient population of chronic, severely ill psychotic and organic patients require custodial support, and an optimally functioning, contemporary hospital setting may be far preferable for them to a vegetative existence at the periphery of the local community.

Clinical experience and research regarding the effectiveness of day hospitals has established the importance of this therapeutic modality. Day hospitals may be a viable alternative for acute crisis intervention on a short-term basis, and for all cases that would require long-term hospitalization but where a more restricted structure, such as the day hospital can provide, is sufficient. For example, many borderline patients with indication for long-term hospitalization might be treated in a day hospital as an alternative, while the severe nature of destructiveness and self-destructiveness of other borderline patients would contra-indicate anything but full hospitalization. Other day hospital programs should focus on the transitional needs

of patients who are moving from hospital treatment, particularly long-term hospital treatment, into outpatient treatment and the community.

The treatment objectives and techniques would vary significantly for all these patient groups. Psychiatric inpatient treatment, for example, geared to bringing about significant structural intrapsychic change in borderline personality organization, so that the patient can move into an outpatient treatment setting not possible before, requires an intense utilization of the psychosocial modalities of treatment provided by the application of psychoanalytic knowledge to intensive psychotherapy in the hospital and the application of the diagnostic and therapeutic utilization of group processes and therapeutic community models. Such a hospital treatment program is very different from one required for the ongoing social support and gradual rehabilitation of severely regressed, chronic schizophrenic patients.

The specialization of hospital services may permit a functional distribution of human and financial resources within the large psychiatric hospital which would permit it to provide to some extent the intensive treatment given by the small hospital. Modifying the large public hospital in this way would eliminate some of the remaining striking differences between it and the small private psychiatric hospital in the United States.

The development of specialized geriatric services is a new trend that may dramatically change the hospital milieu for the older patient population, who were previously indiscriminately mixed with the chronic schizophrenic patient population. Specialized short-term and long-term geriatric services may significantly contribute to reduce hospital stay for some geriatric patients, particularly for the affective disorders in the aged.

The function of the day hospital as a transitional setting for former inpatients is complemented by the development of halfway houses, apartment-living programs (where former hospital patients share responsibility and life in an apartment setting), foster home care, and the outpatient clubs and social organizations that may be organized around outpatient clinics.

The concept of continuity of care has been critically revised in recent times. Having the same staff throughout a patient's treatment progress from inpatient, to day hospital, to outpatient treatment, is expensive and usually nonfunctional. The inpatient staff gradually become overloaded with a growing aftercare and outpatient population, which leads to "burn out" and inefficiency in utilizing treatment resources. Ideally, continuity of care should be provided by a primary therapist who starts out with the patient in the hospital and maintains a psychotherapeutic relationship with the patient outside the hospital. In this regard, the need for an integrated inpatient hospital program with a staff of psychiatrists fully committed to that program seems more important than maintaining contact between the patient and his previous psychotherapist throughout hospital treatment, particularly when long-term inpatient treatment is involved: here it is usually preferable to change therapists.

At this time, in the leading private psychiatric hospitals that are still at the forefront of psychiatric hospital treatment in the United States, treatment modalities include a broad range of group methods, various applications of hospital milieu treatment, therapeutic community approaches, psychopharmacological treatment, psychosocial rehabilitation, and psychotherapy. The team approach to psychiatric patients developed in the last twenty years conceives of nursing, psychiatric social work, therapeutic activities, and psychology as integrated parts of the medical and psychiatric treatment. Each professional in these various disciplines contributes both special skills and a personal interaction with the patient, in which transference and countertransference developments are utilized as part of the diagnosis of the total social environment surrounding the patient. This immediate social environment is under the im-

pact of the patient's intrapsychic conflicts and influences the patient in turn. The organization of the network of formal and informal, individual, small group, and large group experiences in the hospital is the background against which such multiple transferences and countertransferences played out in individual and group situations can be diagnosed and therapeutically utilized.

It seems to me that the hospital is best conceived of as an experimental social setting within which the patient can display his predominant constellations of pathogenic internalized object relations, and in which these activated object relations can be diagnosed and therapeutically modified in the context of individual and group psychotherapeutic interactions. The contributions of psychoanalysis to hospital treatment, and the contributions of therapeutic community approaches have facilitated a concept of hospital administration and structure that minimizes the dangers of the hospital as a "total institution", and maximizes the opportunity for new learning experiences.

A major task American pyschiatry is engaged in at this time is to disentangle the new technical knowledge obtained in the last fifty years from the ideological distortions and the social extrapolations of that knowledge. In practice, the optimal utilization of this knowledge requires that the psychiatric hospital permit the utilization of staff's emotional reactions to patients for therapeutic purposes, and promote an atmosphere of openness and a functional — in contrast to an authoritarian — administrative structure. A functional administrative structure is not a democratic one, and the distinction between functional administration and democratic political organization is one aspect of the new learning that is being integrated at this time. By the same token, modern conception of organizational management may be one skill that the contemporary hospital psychiatrist has to acquire. In addition, the hospital psychiatrist needs to combine knowledge of the full range of now available psychopharmacological and psychosocial treatments, including the expertise in the diagnosis and therapeutic utilization of group processes.

In conclusion, the 1980s begin under the sign of efforts to integrate traditionally opposite modalities such as, biological and psychological approaches in psychiatry, the functions of the large public and the small private psychiatric hospitals, the alternatives of social reintegration and of provision of an inpatient "moratorium" for the psychiatric patient, with a new awareness of the differing therapeutic needs of specialized subgroups of patients.

References

Belknap I 1956 Human Problems of a State Mental Hospital. New York: McGraw-Hill

Bion W R 1961 Experiences in Groups. New York: Basic Books

Caudill W 1958 The Psychiatric Hospital as a Small Society. Cambridge: Harvard University Press

Feigelson E 1980 Hospitalization and milieu therapy: Overview of psychiatric hospitalization. In: Kaplan H I, Freedman A M, Sadock B J (eds.) Comprehensive Textbook of Psychiatry, III. Baltimore: Williams and Wilkins. pp. 2359—2381

Goffman E 1961 Asylums. New York: Anchor, Doubleday

Herz M I 1971 Day versus inpatient hospitalization: A controlled study. American Journal of Psychiatry, 127:107

Herz M I 1980 Partial hospitalization, brief hospitalization and aftercare. In: Kaplan H I, Freedman A M, Sadock B J (eds.) Comprehensive Textbook of Psychiatry, III. Baltimore: Williams and Wilkins, pp. 2368—2380

Herz M I et al., 1975 Brief hospitalization of patients with families: Initial results.American Journal of Psychiatry 132:413

Kernberg O 1976 Toward an integrative theory of hospital treatment. In: Object Relations Theory and Clinical Psychoanalysis. New York: Jason Aronson, pp. 241—276

Kernberg O 1980 Regression in groups. In: Internal World and External Reality: Object Relations Theory Applied. New York: Jason Aronson, pp. 211—234

Kernberg O 1981a Some issues in the theory of hospital treatment. Journal of the Norwegian Medical Association, 101, 837—843

Kernberg O 1981b Advantages and liabilities of therapeutic community models. Proceedings of the VII International Congress of Group Psychotherapy. Copenhagen, 1980. In: Individual and the Group: Boundaries and Interrelations in Theory and Practice, Vol. I. London: Plenum Press

Knight R 1953a Borderline states. In Knight R P, Friedman C R (eds.) Psychoanalytic Psychiatry and Psychology. New York: International Universities Press, 1954, pp. 97—109

Knight R 1953b Management and psychotherapy of the borderline schizophrenic patient. In: Knight R P, Friedman C R (eds.) Psychoanalytic Psychiatry and Psychology. New York: International Universities Press, 1954, pp. 110—122

Langsley D 1980 Community psychiatry. In: Kaplan H I, Freedman A M, Sadock B J, (eds.) Comprehensive Textbook of Psychiatry, III. Baltimore: Williams and Wilkins, pp. 45: 2836—2854

Main T F 1957 The ailment. Brit. J. Med. Psychol., 30: 129—145

Menninger W 1936 Psychiatric hospital therapy designed to meet unconscious needs. In: Psychiatrist for a Troubled World, Vol. 1, 375—385, 1967

Pasamanick, B. et al. 1967 Schizophrenia in the Community: An Experimental Study in the Prevention of Hospitalization. New York: Appleton-Century-Crofts

Rice A K 1965 Learning for Leadership. London: Tavistock Publications

Simmel E 1929 Psychoanalytic treatment in a sanatorium. International Journal of Psycho-Analysis, 10: 70—89

Stanton A M, Schwartz M 1954 The Mental Hospital. New York: Basic Books